SUMMARY OF THE FEDERAL EMPLOYEES' HEALTH INSURANCE AMENDMENTS OF 1983

Section 101 simply adds a couple of new definitions to the definitions in the current law.

Section 102 establishes a new health benefits program for annuitants. One carrier will offer two options for a three-year period to annuitants. The first option will be basically a high option plan, and the second option will be a Medicare wraparound. The benefits are legislated. Basically, the level of benefits will be equal to the Blue Cross/Blue Shield high option provided in 1983. In addition, care provided in psychiatric hospitals and skilled nursing facilities will be covered as well as alcoholic and drug rehabilitation programs. Plus, provision of dental care is included. There will be $150 deductible for the annuitant plans. There will be 80/20% coinsurance ratio for all in-hospital services and 90/10% ratio for those outside of the hospital--except in emergencies where no coinsurance will be applied.

The Medicare wraparound will consist of a plan whose benefits, when combined with the Medicare provisions, will equal benefits provided for under the high option. All Medicare coinsurance and deductibles will be paid for by the wraparound subject to the wraparound's deductible and coinsurance.

Spouses and dependents who are Medicare eligible will be covered by the wraparound despite the Medicare eligibility of the annuitant. Those who are not Medicare eligible will be entitled to be covered by the high option plan.

There will be a $1,500 catastrophic limit for individuals and $2,500 for family.

The government will be required to bid for the insurance carrier who can provide the benefits at the lowest premiums. The government will contribute 80% toward the premium for the high option and 70% toward the premium for the wraparound.

Annuitants may also join health maintenance organizations.

Section 103 authorizes either the service benefit plan, the indemnity benefit plan, or any employee organization plan the ability to offer the annuitant option. In addition, it establishes the authority to solicit bids and contract for the annuitant option.

Section 201(a) requires that an employee organization plan be reinsured either by other companies in a pool arrangement or be unwritten by another insurance carrier. This requirement will not take effect until three years after the date of enactment of the legislation. Subsection(b) requires that any contract entered into must contain a statement explaining any changes in benefits, maximums and limitations and exclusions in the program. Subsection(c) authorizes OPM to contract with a health maintenance organization that is either federally qualified under the HMO Act or meets the requirements of federal qualification as determined by OPM. Subsection(d) requires that all plans carry reasonable deductibles and coinsurance. Plans may reduce the deductibles and coinsurance for innovative benefits and may waive them for arrangements made with providers

where the cost of services is equal to or less than the costs explicitly established for similar services in the Medicare Act. Subsection(d) also prohibits any plan from offering more than two options but does not prohibit an underwriter from underwriting more than one carrier who happens to offer two options. Finally, the subsection prohibits OPM from requiring that any carrier offer more than one option.

Section 202 amends the list of benefits that are optionally provided by the various carriers in Section 8904, Title V. Instead of the option to provide these benefits, the carriers are required to offer them. In addition, it also requires that the carriers offer mental health care. The section also applies a catastrophic protection limit on all of the health carriers for active employees. Catastrophic protection would assure that any out-of-pocket expenses by the employee for health care covered under the health plan could not exceed $3,000 per person or $6,000 for a family. These figures are intended only as maximums. In other words, any carrier can offer catastrophic protection that is less than the amounts provided under law. In addition, the catastrophic amounts are indexed yearly by the Consumer Price Index.

Section 203 alters the contribution formula by the government. Instead of the government's contribution being based upon the average of the big six premiums, the government's contribution will now be 70% of the weighted average of all the premiums. The weighted average will depend upon the number of enrollees in

each carrier's plan. In other words, those plans which have more enrollees will be given greater weight in determining the government's contribution. The government is prohibited from contributing more than 100% to a carrier's premium.

Section 204 establishes a cost containment program for the health carriers. The bill specifies various features that each carrier must comply with. They include other party liability, claims adjudication, innovative benefits, utilization review, fraud and abuse, management strategies and data base, health education, and preferred provider arrangements. Each carrier will be required to pay into the health trust fund 2% of its total premium . OPM shall audit each carrier's cost containment program to determine its effectiveness and then give them a rating for each part and then an overall summary rating of excellent, satisfactory, or poor. Depending upon the rating will be the award of money aggregated from the 2% surcharge. Those rating excellent and satisfactory will receive some award; obviously those receiving an excellent rating will receive a greater award. Those receiving poor ratings for two consecutive years will be terminated from the program subject to a hearing on the record and appealable to the Court of Appeals under the Administrative Procedures Act. Finally, the Office of Personnel Management shall report to Congress every year on the progress of the cost containment program.

Section 205 requires that prior to any change in benefits or premiums in the health plan, OPM must organize an open season. This would not preclude the Office from reducing the frequency of open seasons, as they can do in current law, but would require that any change in benefits or premiums be made available to employees prior to the employees' participation in that particular health plan. The section also requires that OPM make available to every employee and annuitant fifteen (15) days prior to an open season summaries of all of the health plans available to those employees.

Section 206 establishes a three-year experimental program for the Office of Personnel Management. OPM is required to carry out this program in three large areas in the United States where a substantial number of federal employees are located. OPM shall negotiate agreements with providers of health care to provide discount services for the employees of the government. Where OPM makes these agreements, the carriers may waive deductibles and coinsurance if their subscribers go to those providers.

Section 301 is simply technical amendments.

Section 302 makes the effective date the date of enactment except for the reinsurance requirement, which takes effect three years after the date of enactment.